U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 25Jan2002

CASE NO.: 2000-BLA-529

In the Matter of

JAMES L. ALLISON,
Claimant

v.

ELK RUN COAL COMPANY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Parties-in-Interest

Appearances:

Ray E. Ratliff, Jr., Esquire,
For the Claimant

Mary Rich Maloy, Esquire,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claimant's application for benefits which was filed on April 14, 1999, (DX 1)[1], under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*[2] ("Act"). The Act and

[1] The following abbreviations are used for reference within this opinion: DX-Director's Exhibits; CX- Claimant's Exhibit; EX- Employer's Exhibit; TR- Hearing Transcript; Dep.- Deposition.

[2] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however,

implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R.§ 725.101

PROCEDURAL HISTORY

Claimant filed his claim for benefits with the Department of Labor on April 14, 1999. (DX 1). On September 9, 1999, a Department of Labor claims examiner made an initial finding of entitlement to benefits. (DX 22). Thereafter, the District Director also made a determination of eligibility on December 14, 1999. (DX 33). On January 14, 2000, the employer objected to the findings of the District Director and requested a formal hearing with an Administrative Law Judge. (DX 36).

On August 9, 2001, I was assigned this case. On August 28, 2001, I held a hearing in Charleston, West Virginia, at which time the claimant and employer were represented by counsel.[3] The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibit 1, Employer's exhibits 1-14, and Director's exhibits 1-37 were admitted into the record.

ISSUES

I. Whether the miner has worked at least 26 years in or around one or more coal mine?

II. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

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were to apply only to claims filed on or after January 19, 2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations.

[3] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment is determinative of the circuit court's jurisdiction.

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether the miner has two dependents for purpose of augmentation?

VI. Whether Elk Run Coal Company, Inc., is the responsible operator?

FINDINGS OF FACT

I. Background

A. Coal Miner

The parties agree and I find that the evidence of record establishes that the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations. The length of that coal mine employment is at issue and is discussed below.

B. Date of Filing[4]

The claimant filed his claim for benefits on April 14, 1999. (DX 1). Accordingly, I find the claim is governed by 20 C.F.R. Part 718.

C. Responsible Operator

I find that Elk Run Coal Company, Inc., is the last employer for whom the claimant worked a cumulative period of at least one year and it is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations.[5] This finding is based upon the claimant's testimony that his last coal mine employment of

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[4] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed . . . .

[5] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R.§ § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut the first, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). Neither presumption has been rebutted in this case.

at least one year was with Elk Run, (TR 13), his employment history form, in which he listed Elk Run as his last employer from 1982 through 1994, (DX 2), his FICA Earnings statement, (DX 3), and the employer's failure to further contest the issue following Mr. Allison's testimony at the hearing.

D. Length of Coal Mine Employment

Mr. Allison alleged 26 years of coal mine employment. (DX 1: TR 13). His Social Security records are not complete and only confirm seven quarters of coal mine employment with Valley Camp Coal Company in 1967 and 1975, and ten quarters with The Carbon Fuel Company from 1973 through 1977. (DX 4). On his Employment History form, the claimant listed five different coal mine employers from February 1968 through May 1982 and August 1982 through November 1994. (DX 2). These include Valley Camp Coal Company, for whom he worked from January 1967 to October 1967 and April 1975 to December 1975; Allied Chemical, for whom he worked from February 1968 to November 1973 and February 1977 to April 1979; Carbon Fuel Company, for whom he worked from November 1973 to April 1975, December 1975 to February 1977, and April 1979 to August 1980; Armco, now AK Steel Corp., for whom he worked from August 1980 to May 1982; and Elk Run Coal Company, for whom he worked from August 1982 to November 1994. This form confirms 26 years of coal mine employment. The FICA Earnings statement validates the work claimed at Allied, Carbon, Armco, and Elk Run. (DX 3). Accordingly, I credit Mr. Allison with 26 years of qualifying coal mine employment. I further find that his last coal mining job consisted of operating a shuttle car and a continuous miner.

E. Dependents

Claimant testified that he married his wife, Vivian Allison, in 1992, although the marriage license shows a date of May 25, 1994. (TR 10; DX 8). Based on this evidence, I find that claimant's wife, Vivian, is his dependent for purposes of augmentation of benefits under the Act.

Claimant's daughter, Heather, was born December 8, 1980, and is a college student. (TR 10; DX 10, 11). Prior to Heather's turning 18, claimant paid court-ordered child support, but that ceased upon her reaching the age of majority. (DX 9; TR 12). Although claimant testified that Heather is a full time student at West Virginia State, a document completed by the registrar of Marshall University showed that as of September 21, 1999, she was a part-time student. (TR 10; DX 11). Claimant testified that other than buying a vehicle for his daughter when she started college, he does not financially support her. (TR 11).

Pursuant to § 725.209, a miner's child is deemed his dependent if she is unmarried and a full-time student at an accredited school, college, or university. § 725.209(a) and (b). Although the document from Marshall University revealed that Heather was not a full-time student, claimant testified nearly two years after the dating of the document that Heather is a full-time student. I find claimant's testimony credible and therefore conclude that he has established that Heather is also his dependent for purposes of augmentation of benefits under the Act.

F. Personal, Employment and Smoking History

The claimant was born on January 3, 1941. (DX 1). He testified that he worked as a coal miner for 26 years. (DX 1; TR 13). He last worked for Elk Run Coal Company, and his last date of employment was November 17, 1994. (TR 13). During his last year of mining, he operated a shuttle car and a continuous miner. (TR 13). The work was heavy, requiring him to lift a 30-pound miner cable every 20 minutes. (TR 13, 15). Mr. Allison testified that he could not return to his last mining job because of his breathing problems. (TR 20).

After ceasing coal mine employment, claimant experienced difficulty breathing, sleeping, and climbing stairs. (TR 15). He uses a nebulizer and an inhaler. (TR 16). In 1989 and 1999, claimant underwent heart surgery. (TR 17). Mr. Allison testified that he smoked a pack of cigarettes a day from the age of 17 or 18 until June 2001. (TR 18).

II. Medical Evidence

A. Chest X-rays

The radiographic evidence submitted in the record of this matter is contained in Appendix A, which is attached hereto.

Thirty readings of nineteen X-rays, taken between November 24, 1982 and March 25, 2000, were submitted. Ten were read as positive.

B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Trac-ing**	**Compre-hension Cooper-ation**	**Qualify* Conform****	**Dr.'s Impression**
Crisalli 2/22/94 DX 28 Post-Broncho-dilator	53 67"	2.45 2.66	105 —	3.88 4.04	Yes	Good Good	No/Yes No/Yes	Mild expiratory air flow obstruction. No restrictive defect. Moderate air trapping. Mild diffusion defect. Significant post bronchodilat or improvement.
Santiago 9/11/96 DX 28	55 67"	2.39	–	3.49	Yes	Not provided	No/Yes	
Walker 5/21/99 DX 12	58 66"	1.37	52	2.74	Yes	Good Good	Yes/Yes No/Yes	Found acceptably by Dr. Dominic J. Gaziano on 6/22/99. (DX 12). Dr. Gaziano is board certified in internal medicine and chest disease.
Zaldivar 10/27/99 DX 27 Post-bronchodilator	58 67"	1.63 1.93	71 84	3.07 3.45	Yes	Not provided	Yes/Yes No/Yes	Moderate reversible obstruction. Air trapping by lung volume. Moderate diffusion abnormality in large part due to the effect of smoking.

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Trac-ing	Compre-hension Cooper-ation	Qualify* Conform**	Dr.'s Impression
Dahhan 3/25/00 EX Post-bronchodilator	59 64"	1.33 1.46	39.63 54.68	2.86 3.29	Yes	Good Good	Yes/Yes Yes/Yes	Moderately severe obstructive ventilatory defect.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

For a miner of the claimant's height of 67 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.92 for a male 53 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.43or an MVV equal to or less than 77; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	Age	FEV_1	FVC	MVV
67"	55	1.88	2.42	75
66"	58	1.78	2.27	71
67"	58	1.84	2.35	74
64"	59	1.58	2.02	63

C. Arterial Blood Gas Studies[6]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

[6] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii) or (iv) of this section shall establish a miner's total disability: . . .
(2) Arterial blood gas tests show the values listed in Appendix C to this part . . . .

Date Ex.#	Physician	pCO_2	pO_2	Qualify	Physician Impression
5/21/99 DX 15	Walker	44	64	No	
3/25/00 EX Rest Exercise	Dahhan	 40.2 39.9	 72.9[7] 87.3	 No No	Minimum hypoxia with adequate ventilation at rest; normal values after exercise.

+ Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

The record contains the medical records of Drs. Paul Francke, Jr., S.K. Thareja, Robert Smith, and Stafford G. Warren, all of whom treated Mr. Allison between November 1982 and March 1990 for kidney and cardiac conditions. (DX 26). On November 24, 1982, Dr. Francke performed an intravenous pyelogram and a chest examination. He found normal lungs and two kidney stones.

Mr. Allison underwent stress thallium tests on December 27, 1989, January 22, 1990, and March 23, 1990. Dr. Thareja supervised the first and last of these tests. He found an infarct and ischemia in the inferior portion of the left ventricle. Dr. Smith, who administered the January 1990 test, found the same. On January 19, 1990, Dr. Warren performed a percutaneous transluminal coronary angioplasty of the right coronary artery proximal graft.

On April 27, 1992, Dr. Paul Bachwitt examined the claimant at the request of the State of West Virginia Workers' Compensation Fund. (DX 26). He initially considered the claimant's history of a coronary bypass and angioplasty, as well as an injury to his right shoulder and neck resulting from a work-related injury in January 1991. Dr. Bachwitt considered the results of chest X-rays taken after the injury, which showed previous bypass surgery with metallic sutures in the mid-sternum, and an MRI of the cervical spine, which showed central bulging at C7.

Dr. Bachwitt listened to Mr. Allison's complaints of a stiff neck and numbness in the fingers of his right hand. Mr. Allison reported that his last coal mining job was as a shuttle car operator nine hours a day, six days a week. Dr. Bachwitt concluded that Mr. Allison was not gainfully employable. While he felt a cervical laminectomy may be beneficial, he deferred to the treating physician's reluctance to perform same. Dr. Bachwitt opined that Mr. Allison had reached maximum medical improvement without surgery and that he had 6% permanent partial disability due to the disc lesion.

[7] Although the report shows a pO2 of 40.2, Dr. Dahhan explained at his deposition that the correct value was 72.9 and that the 40.2 value was a misprint. (EX 14, p. 13).

Dr. Alfredo C. Velasquez examined Mr Allison at the request of Dr. Thopsic V. Jagannath for a work-related injury to the back occurring on November 17, 1994, in a report dated December 20, 1994. (DX 26). X-rays of the lumbosacral spine showed some degenerative changes. Dr. Velasquez prescribed physical therapy and Lortab.

On May 16, 1995, Dr. Smith performed another stress thallium test. (DX 26). It revealed a moderate sized proximal inferior and inferobasal wall myocardial infarction without evidence of associated ischemic changes. An August 16, 1995 stress thallium test showed the condition was unchanged.

On May 26, 1995, Dr. Stafford performed a cardiac catheterization upon the referral of Dr. Jagannath. (DX 26). Dr. Stafford considered a history of Black Lung disease according to Dr. Crisalli and a history of smoking one pack of cigarettes a day since the age of 16 or 17 until Mr. Allison quit about ten months before. Physical examination showed clear lungs. After the procedure, Dr. Stafford diagnosed progression of the cardiac disease to closure of two saphenous vein bypass grafts and significant double vessel coronary artery disease with a new stenosis in diagonal coronary artery.

At the request of the Department of Labor, Dr. James H. Walker, M.D., examined Mr. Allison on May 21, 1999. (DX 14). Dr. Walker is board-certified in surgery and thoracic surgery. He initially noted the claimant's family history of heart disease and Mr. Allison's history of colds, pneumonia, pleurisy, heart disease, and high blood pressure for the last eight to nine years. Dr. Walker noted that the claimant underwent coronary artery bypass surgery in 1989 and a coronary angioplasty in 1991 and 1999.

Dr. Walker considered a history of smoking one package of cigarettes a day since the age of 20 and complaints of yellow sputum production, wheezing for four to six years, a cough, chest pain, and the ability to walk only one-half mile on level ground. Mr. Allison also reported that he has slept on two pillows for the last four years. Physical examination revealed suppressed breath sounds and wheezing. Furthermore, Dr. Walker pondered a 26-year coal mine employment history ending in November 1994 due to injury. He learned that Mr. Allison performed various jobs but last worked as a miner operator.

Dr. Walker performed a chest X-ray, a pulmonary function study, an arterial blood gas study, and an EKG. The x-ray was interpreted by Dr. Hayes, a B-reader and board certified radiologist, as indicating pneumoconiosis "r/q" with a profusion of 2/3 throughout all zones. The pulmonary function study showed severe obstructive ventilatory defect, and the blood gas study revealed a moderate reduction in the resting PO2. The EKG was normal.

Dr. Walker diagnosed coal worker's pneumoconiosis, coronary artery disease, and bronchitis with bronchospasm due to occupational dust and cigarette smoking. In his opinion, the claimant cannot return to his last mining job.

At the request of the employer, Dr. George L. Zaldivar, M.D., examined the claimant on October 27, 1999. (DX 29). Dr. Zaldivar is board-certified in internal medicine and pulmonary

diseases. Dr. Zaldivar initially noted that Mr. Allison has been experiencing shortness of breath for the past seven years. Dr. Zaldivar also noted that Mr. Allison has had heart trouble, including coronary bypass surgery in 1989, and back problems. Furthermore, Dr. Zaldivar noted Mr. Allison's complaints of wheezing, an occasional cough, and swelling of the feet and ankles. Dr. Zaldivar took note of the many medications the claimant takes. Regarding Mr. Allison's smoking history, Dr. Zaldivar indicated that the claimant began smoking at the age of 16 and smoked no more than a pack of cigarettes a day until earlier in the month of October 1999, when Wellbutrin helped him quit.

During his examination of Mr. Allison, Dr. Zaldivar conducted a pulmonary function study and an X-ray. The chest X-ray, dated 10/27/99, was interpreted by Dr. Zaldivar, who is a B-reader, as indicating pneumoconiosis "r/r"with a profusion of "1/1" throughout all lung zones. He added that the x-ray showed previous coronary bypass surgery, that granulomas were also present, and that the abnormal x-ray findings might be the result of recent pneumonia. Additionally, Dr. Zaldivar reported that Mr. Allison's ventilatory function studies revealed moderate, reversible obstruction. Dr. Zaldivar added that the moderate diffusion abnormality was in large part due to the effects of smoking. Dr. Zaldivar concluded that Mr. Allison has carotid artery disease, post coronary bypass surgery, and angina.

From January 14 to January 21, 2000, Mr. Allison was admitted to the Charleston Area Medical Center under the care of Dr. Ramanathan Sampath, M.D. (EX 12). The hospital records and operative note are of record. X-rays were taken on January 14, January 16, and January 20. Physical examination revealed lungs that were clear to auscultation. Mr. Allison underwent a double coronary artery bypass graft because of returning angina symptoms. Dr. Sampath diagnosed chronic obstructive pulmonary disease.

At the request of the employer, Dr. Abdulkadar Dahhan, M.D., examined Mr. Allison on March 25, 2000. (EX 1). His report is dated March 27, 2000. Dr. Dahhan is board certified in internal medicine and pulmonary disease. He initially noted a coal mine employment history of 26 years as a roof bolter, continuous miner operator, and lastly as a shuttle car operator. Dr. Dahhan also noted a smoking history of one and one-half packages of cigarettes a day, commencing at the age of 16 and ending just three months prior to the examination, for a total of 43 years.

Dr. Dahhan noted a history of a daily cough with productive clear sputum, frequent wheezing, dyspnea on exertion such as a flight of stairs, and chest pain brought on by exercise. Dr. Dahhan considered Mr. Allison's use of an inhaler and several other medications for such conditions as frequent edema, hypertension, and coronary artery disease. Dr. Dahhan was given a history of coronary bypass surgery in 1989 and 2000.

Physical examination revealed good air entry to both lungs, scattered bilateral expiratory wheeze, no gallops or murmurs, and no crepitation or pleural rubs. Dr. Dahhan conducted a pulmonary function study, an EKG, an arterial blood gas study, and an X-ray. The chest X-ray, dated 3/25/00, was interpreted by Dr. Dahhan, who is a B-reader, as indicating pneumoconiosis "r/q" with a profusion of "1/1" throughout all lung zones. In Dr. Dahhan's opinion, Mr. Allison's ventilatory function studies revealed a moderately severe obstructive ventilatory defect. Dr. Dahhan added that the blood gas

studies showed minimum hypoxia at rest but normal values after exercise. He further expounded that the EKG revealed regular sinus rhythm and that a carboxyhemoglobin level test indicated a smoking habit of over one pack per day.

Dr. Dahhan further reviewed the following medical evidence: x-ray readings of the November 1982, January 1987, September 1989, June 1990, May 1994, and October 1000 x-rays, pulmonary function studies from March 1994, May 1999, and October 1999, a blood gas study from May 1994, hospital records, and the reports of Drs. Walker and Zaldivar. Dr. Dahhan diagnosed simple pneumoconiosis and a moderately severe, partially reversible obstructive ventilatory defect. From a respiratory standpoint, Mr. Allison does not retain the physiological capacity to continue his previous coal mine employment, according to Dr. Dahhan. Dr. Dahhan opined that the pulmonary disability is due to the miner's chronic obstructive lung disease which takes the form of chronic bronchitis and emphysema; it is not due to coal dust exposure or pneumoconiosis. Dr. Dahhan buttressed his opinion with the facts that Mr. Allison does not have complicated pneumoconiosis or pulmonary massive fibrosis; the obstructive lung disease is reversible, which is inconsistent with the permanent effects of coal dust on the respiratory system; the miner's smoking history is more than sufficient to cause a disabling obstructive ventilatory defect; and there has been no exposure to coal dust since 1994.

Dr. Dahhan was deposed on August 17, 2001. (EX 14). Dr. Dahhan provided his credentials and reviewed the results of his March 27, 2000 examination of Mr. Allison. Dr. Dahhan explained that there was significant reversibility of Mr. Allison's pulmonary disability following bronchodilator administration. The same was true of Dr. Zaldivar's test. Dr. Dahhan again stated that Mr. Allison is incapable of returning to coal mine employment. He opined that the cause of the respiratory impairment is cigarette smoking.

At the request of employer's counsel, Gregory J. Fino, M.D., reviewed Mr. Allison's medical records, including physician reports, chest X-rays, pulmonary function study results and arterial blood gas results. In a report dated May 17, 2000, Dr. Fino submitted his findings. (EX 5). Dr. Fino is a B-reader and is board-certified in internal medicine and pulmonary diseases.

Dr. Fino noted Mr. Allison's history of coal mining employment as well as his extensive smoking history. Dr. Fino found radiographic evidence of simple pneumoconiosis but opined that there was not evidence of clinical coal workers' pneumoconiosis. He based this opinion on four factors: evidence of an obstructive, and not a restrictive, ventilatory abnormality based on spirometric testing; evidence of a reversible obstruction; evidence of elevated lung volumes, indicating a disease such as emphysema, asthma, or chronic obstructive bronchitis, but not fibrosis found in pneumoconiosis; and normal diffusing capacity in 1994 which was reduced five years later–a condition consistent with smoking.

Dr. Fino maintained that Mr. Allison has a disabling respiratory impairment due to smoking which prevents him from returning to his last coal mining job. He noted that the claimant is also disabled secondary to his significant coronary artery disease. In his opinion, Mr. Allison would be as disabled as he is even if he had never stepped foot in a coal mine.

At the request of counsel for employer, Dr. Samuel V. Spagnolo, M.D., reviewed Mr. Allison's medical records, including physician reports, chest X-rays, pulmonary function study results, and arterial blood gas studies. (EX 6). In a report dated May 14, 2000, Dr. Spagnolo, who is board certified in internal medicine and pulmonary diseases, submitted his findings.

Dr. Spagnolo noted Mr. Allison's history of coal mine employment as well as his smoking history. He opined that Mr. Allison does not have coal workers' pneumoconiosis based on the examinations by Drs. Warren, Walker, Dahhan, and Zaldivar which failed to demonstrate physical findings of interstitial lung disease such as diffuse crackles, dullness to percussion, and significant finger clubbing. He further relied upon the X-ray readings by Drs. Scott, Kim, and Wheeler, and the pulmonary function studies elicited by Drs. Walker, Dahhan, and Zaldivar.

Dr. Spagnolo believed that the spirometric values were the result of the claimant's long abuse of cigarettes. Like Dr. Fino, Dr. Spagnolo relied on the partial reversibility of the pulmonary impairment following bronchodilator administration and the lack of reduction in total lung capacity to reach this conclusion. Thus, Dr. Spagnolo maintained that Mr. Allison is not limited by a primary lung condition or impairment attributable to pneumoconiosis and could perform his prior coal mine work. He added that this conclusion would not change even if Mr. Allison were deemed to have coal workers' pneumoconiosis.

At the request of counsel for employer, James R. Castle, M.D., reviewed Mr. Allison's medical records, including physician reports, chest X-rays, pulmonary function study results and arterial blood gas results. In a report dated May 19, 2000, Dr. Castle submitted his findings. (EX 7). Dr. Castle is a B-reader and is board-certified in internal medicine and pulmonary diseases.

After reviewing Mr. Allison's records, Dr. Castle opined that Mr. Allison has radiographic evidence of pneumoconiosis. Dr. Castle maintained that the claimant worked in or around the coal mining industry for a long enough time to have developed the disease if he were a susceptible host. Dr. Castle also stressed that Mr. Allison's history of smoking cigarettes for at least 38-40 years at a rate of at least one pack per day is sufficient to have caused chronic obstructive pulmonary disease. Dr. Castle identified coronary artery disease as yet another risk factor for the development of pulmonary symptoms such as chest pain and dyspnea on exertion. Dr. Castle pointed out that the lack of physical findings such as rales, crackles, or crepitations are inconsistent with interstitial pulmonary process like pneumoconiosis.

Dr. Castle opined that Mr. Allison is permanently and totally disabled as a result of moderate airway obstruction due to his long and extensive smoking habit but not due to pneumoconiosis. He noted that the valid physiologic studies did not evince impairment related to coal workers' pneumoconiosis because there is no evidence of a mixed, irreversible obstructive and restrictive ventilatory impairment. Mr. Allison, rather, demonstrated a moderate, partially reversible airway obstruction only, which is typical of COPD due to smoking. He further bolstered his opinion with the fact that the blood gas studies administered by Dr. Dahhan were normal, indicating that Mr. Allison did not have a permanent abnormality of blood gas transfer, thus mitigating against a diagnosis of pneumoconiosis. Because Mr. Allison continued to smoke for several years after leaving the mining

industry, Dr. Castle opined that the claimant's airway disease was neither caused by, contributed to, or aggravated in any way by his coal mining employment or dust exposure.

Dr. Castle was deposed on October 4, 2000, at which time he reiterated the results of his prior opinion, provided his credentials, and further reviewed the reports of Drs. Spagnolo, Fino, and Stewart, as well as Dr. Meyer's reading of the March 25, 2000 x-ray, and the reports of Drs. Wheeler, Scott, and Kim concerning the March 16, 1996 x-ray. (EX 13). Dr. Castle also reviewed five x-rays himself, finding category 1/1 pneumoconiosis with r/r or r/q shaped opacities. Dr. Castle explained that post-bronchodilator pulmonary function studies show whether a pulmonary impairment is reversible and, thus, help explain the etiology of the condition. He informed that conditions such as asthma and bronchitis due to cigarette smoking are reversible conditions, whereas obstruction due to scarring caused by a disease like pneumoconiosis is not reversible. While Dr. Castle again opined that Mr. Allison is totally disabled by his cardiac disease alone, he also found him totally disabled from a pulmonary standpoint. Dr. Castle pointed out, however, that the lack of physical findings consistent with pneumoconiosis and the results of the pulmonary function studies (not consistent with an abnormality due to coal workers' pneumoconiosis) led him to conclude that Mr. Allison's disability is not due to pneumoconiosis.

At the request of counsel for employer, Dr. Bruce N. Stewart, M.D., reviewed medical records, including physician reports, chest X-rays, pulmonary function study results and arterial blood gas results. In a report dated August 1, 2000, Dr. Stewart submitted his findings. (EX 9). Dr. Stewart is board certified in internal medicine and pulmonary diseases.

Dr. Stewart believed that Mr. Allison suffers from simple coal workers' pneumoconiosis based on the x-ray evidence and coal mine employment history. He also found the claimant totally disabled by his respiratory impairment, which he found to be of the obstructive type with no evidence of restriction. Dr. Stewart pointed to Mr. Allison's elevated lung volumes, or hyperinflation, which is common in smoking-induced chronic obstructive pulmonary disease. Dr. Stewart was in agreement with the opinions and reasoning of Drs. Fino and Castle. Thus, he opined that Mr. Allison's impairment was not caused in whole or in part by coal dust exposure or pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205*; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

B. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [8] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[9] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

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[8] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[9] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

The Board has recently adopted the Director's position to hold that "a transient aggravation of a non-occupational pulmonary condition is insufficient to establish pneumoconiosis as defined at Section 718.201." *Henley v. Conan and Co.*, 21 B.L.R. 1-148, BRB No. 98-1114 BLA (May 11, 1999).[10]

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[11] 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant has not established pneumoconiosis pursuant to subsection 718.202(a)(2) by autopsy or biopsy evidence. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable. There is no evidence of complicated pneumoconiosis in this case.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.[12] 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of

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[10] As a result, the Board concluded that the ALJ erred in finding legal pneumoconiosis based upon medical opinions which diagnosed a temporary worsening of pulmonary symptoms due to exposure to coal dust, but no permanent effect. Id.

[11] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis, and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

[12] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. 2/3 is the fourth highest profusion and 3/2 the third. *See* N. LeRoy Lapp, "A Lawyer's Medical Guide to Black Lung Litigation," 83 *W. Va. Law Review* 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-Certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit holds that a judge may afford more weight to recent medical evidence. *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has <u>improved</u>, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

In the present claim, nineteen readings of thirty X-rays, taken between November 24, 1982 and March 25, 2000, were submitted. A summary and an analysis of the X-rays submitted in the present claim is as follows. The first ten X-rays, taken between November 24, 1982 and February 12, 1992, were not classified under the ILO classification scheme. None of the reviewing physicians interpreted these X-rays as positive for pneumoconiosis.

The March 16, 1996 X-ray was unanimously found negative for pneumoconiosis by Drs. Wheeler, Scott, and Kim. All three of these physicians are both B-readers and board-certified radiologists.

The September 11, 1996 x-ray was found positive for pneumoconiosis with an ILO classification of 2/2. This film was not reread. The May 21, 1999 X-ray was interpreted by five different dually-certified readers. Dr. Hayes found category 2/3 pneumoconiosis. Drs. Navani and Scott found category 1 pneumoconiosis, and Drs. Wheeler and Kim categorized the film as category 0/1, a negative reading. Dr. Wheeler, however, provided an in-depth explanation which included his belief that some of the nodules he saw could be pneumoconiosis. Because of this allowance and because the majority of readers found the film positive for pneumoconiosis, I consider both of these films as indicative of the presence of the disease.

The October 12, 1999 x-ray was found negative by Drs. Wheeler and Kim. Dr. Wheeler again noted that a few small nodules could be pneumoconiosis but he felt the asymmetrical pattern made that possibility unlikely. The October 27, 1999 X-ray was read as category 1/1 pneumoconiosis by Dr. Zaldivar, a B-reader. This finding was confirmed by Dr. Meyer, a dually-certified reader.

The January 14, 2000, January 16, 2000, and January 20, 2000 x-rays were taken in conjunction with Mr. Allison's hospitalization for cardiac surgery. They were not interpreted for the presence or absence of pneumoconiosis. Therefore, I place very little weight on them.

The March 25, 2000 X-ray was initially interpreted as category 1/1 pneumoconiosis by Dr. Dahhan, a B-reader. Three dually certified readers, Drs. Wiot, Spitz, and Meyer, confirmed this interpretation. Dr. Spitz pointed out that the nodules appear somewhat different than the usual "r" and "u" nodules seen in coal workers' pneumoconiosis. Dr. Meyer questioned whether the condition was histoplasmosis rather than pneumoconiosis, and Dr. Wiot likewise explained that the character of the nodules he saw was somewhat different from those usually seen with pneumoconiosis.

Based on the unanimous readings of the most recent X-ray of evidence, the October 27, 1999 X-ray, and the May 21, 1999 X-ray, considered in conjunction of the credentials of the interpreting physicians, I find that the X-ray evidence, in and of itself, tends to establish the existence of pneumoconiosis based on the ILO classification system.

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

I initially note that there are several reports or records from physicians who did not examine Mr. Allison for the presence or absence of pneumoconiosis and, therefore, did not provide an opinion thereon. These physicians include Drs. Francke, Thareja, Smith, Warren, Bachwitt, Velasquez, and Sampath. Drs. Walker, Zaldivar, Dahhan, Fino, Castle, and Stewart all found the existence of pneumoconiosis. Only Dr. Spagnolo did not. Dr. Fino's finding was based on the radiographic evidence; he found no evidence of clinical pneumoconiosis based on the records he reviewed.

The opinions of Drs. Walker, Zaldivar, Dahhan, Fino, Castle, and Stewart are supported by the X-ray evidence. Dr. Fino's differentiation between radiographic evidence of pneumoconiosis and clinical pneumoconiosis is irrelevant under 20 C.F.R. § 718.201(a). I discount Dr. Spagnolo's opinion on this issue because he chose to defer to the X-ray readings of Drs. Scott, Kim, and Wheeler, whereas later readings by equally qualified interpreters found the existence of pneumoconiosis. Dr. Spagnolo failed to explain why he chose to disregard those readings. Consequently, I find that the medical opinion evidence, especially when viewed in conjunction with the X-ray evidence, establishes the existence of pneumoconiosis under § 718.202.

C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since I credited Mr. Allison with twenty-six years of coal mine employment, he is entitled to receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. The employer has not rebutted this presumption with any evidence that Mr. Allison's coal workers' pneumoconiosis arose other than out of his coal mine employment.

D. Existence of total disability

The claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[13] Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine

[13] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

employment; and lay testimony.[14] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, three of the five pulmonary function test results submitted were qualifying. While the two oldest studies were not qualifying, the May 21, 1999 study produced qualifying results. This study was validated by Dr. Gaziano, who is board certified in internal medicine and chest disease, as acceptable. The October 27, 1999 study also yielded qualifying results prior to the administration of a bronchodilator. The March 25, 2000 test revealed qualifying values both before and after the administration of a bronchodilator. Neither of the last two studies was invalidated. Based on the three most recent studies, I consider the pulmonary function study evidence suggestive of total disability.

Neither of the two arterial blood gas studies submitted were qualifying. Thus, the blood gas study evidence is not indicative of a finding of total disability.

In addition, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional

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[14] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co*., 12 B.L.R. 1-83 (1988).

All the physicians of record conceded that Mr. Allison suffers from a total respiratory disability. Accordingly**,** I find that the evidence of record demonstrates, by a preponderance of the evidence, that Mr. Allison is disabled as required by the Act and Regulations. This finding is supported by the pulmonary function study evidence.

E. Cause of total disability[15]

The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).[16]

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988). Additionally, the Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[17] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the

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[15] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___ , BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

[16] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[17] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, *914 F.2d 35* (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street,* 42 F.3d 241 at 245.

In the instant matter, Dr. Walker failed to provide an opinion on the etiology of Mr. Allison's total respiratory disability. Dr. Spagnolo opined that pneumoconiosis has not resulted in any impairment that would limit Mr. Allison from returning to coal mine employment. Dr. Zaldivar attributed the claimant's impairment in large part to smoking. Drs. Dahhan, Fino, Castle, and Stewart felt that the disability was due to smoking and not pneumoconiosis.

The medical opinion evidence is unanimous that pneumoconiosis has not contributed in any way to Mr. Allison's impairment. I find this opinion highly persuasive. As pointed out by most of the physicians, Mr. Allison has an extensive smoking history. The results of his pulmonary function studies indicate that he has a reversible defect, and Drs. Dahhan, Fino, Spagnolo, Castle, and Stewart cogently explained that pneumoconiosis typically causes mixed, irreversible obstructive and restrictive ventilatory impairment. The significant degree of reversibility indicated an asthmatic component to the claimant's airways disease. The studies failed to reveal an impairment in oxygen transfer, thus further indicating a smoking-related abnormality. Finally, a normal diffusing capacity in 1994, when Mr. Allison ceased coal mining, was reduced five years later with his continued smoking. Drs. Fino and Castle explained that this factor also points toward smoking, and not pneumoconiosis, as the cause of disability. Furthermore, I find the opinions of these physicians well documented and reasoned. They are supported by the review of medical evidence. Drs. Dahhan, Fino, Spagnolo, Castle, and Stewart all possess superior qualifications in the field of pulmonary medicine. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-38 (1990). Finally, the claimant undeniably suffers from coronary artery disease. Dr. Castle testified that the coronary artery disease can account for pulmonary disability. For these reasons, I fully credit their unanimous opinion.

Accordingly, I find that the evidence of record fails to demonstrate, by a preponderance of the evidence, that Mr. Allison's pneumoconiosis is a contributing cause of his total disability. Thus, his claim for benefits must fail.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

While the evidence of record establishes the claimant suffers from pneumoconiosis and a total respiratory disability, claimant has failed to show, by a preponderance of the evidence, that his total respiratory disability is the result of his pneumoconiosis to warrant an award of benefits as set forth by the Act and Regulations.

ORDER

It is ordered that the claim of JAMES L. ALLISON for benefits under the Black Lung Benefits Act is hereby DENIED.

A
RICHARD A. MORGAN
Administrative Law Judge

RAM:aes:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

"APPENDIX A"

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 26 p. 2	11/24/82 11/24/82	Francke	B; BCR	not noted		Lungs are normal.
DX 26 p. 3	1/29/87 1/30/87	Hayes	B, BCR	not noted		No active disease.
DX 26 p. 5	9/15/89 9/15/89	Duncan	B; BCR	not noted		Well defined density in the right posterior medial chest having increased in size slightly since 1/29/87.
DX 26 p. 7	9/29/89 9/29/89	Abramowitz	B, BCR	not noted		Post surgical changes. No acute disease in the chest. Nonspecific density projecting over the mid thoracic spine.
DX 26 p. 10	12/1/89 12/2/89	Abramowitz	B, BCR	not noted		Mild generalized increase in interstitial markings with focal increase in density noted in the left upper lung zone; cannot exclude an early pneumonitis.
DX 26 p. 11	12/15/89 12/18/89	Abramowitz	B; BCR	not noted		Interval resolution of the infiltrate in the left upper lung zone since 12/1/89 exam; nonspecific density projecting over the mid thoracic spine unchanged since prior exam.
DX 26 p. 15	12/28/89 12/28/89	Hayes	B, BCR	not noted		No acute infiltrates or effusions identified.
DX 26 p. 19	6/6/90 6/6/90	Deardorff	B	not noted		Infiltrate in the right lower lobe posteriorly with the appearance of pneumonitis.
DX 26 p. 20	6/15/90 6/15/90	Deardorff	B	not noted		Increasing right pleural effusion; apparent infiltrate in right lower lobe compatible with pneumonia.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 26 p. 25	2/12/92 2/12/92	Holbert		not noted		Resolution of right pleural effusion since 6/15/90; changes of coronary artery bypass graft; possible early congestive heart failure.
EX 10	3/16/96 9/5/00	Wheeler	B; BCR	1	Negative	Healed anterior chest surgery for coronary artery bypass. Subtle small nodular infiltrate in lateral periphery lungs from below clavicles to left CPA and above right CPA and tiny calcified granuloma near right CPA compatible with histoplasmosis. No obvious small nodules in central portion mid and upper lungs but suggest CT scan for precise location of disease.
EX 10	3/16/96 9/5/00	Scott	B; BCR	1	0/1; t/q; 6 zones	Anterior chest surgery; coronary artery bypass.
EX 11	3/16/96 9/22/00	Kim	B; BCR	1	Negative	Non-specific nodular infiltrates in the periphery of lung. Probable thrombosis from granulomatous process. Anterior chest surgery.
CX 1 p. 5	9/11/96 10/7/96	Bassali	B; BCR	2	2/2; r/t; 6 zones	Evidence of previous coronary bypass surgery. No active lung disease.
DX 17	5/21/99 5/27/99	Hayes	B; BCR	1	2/3; r/q; 6 zones	Post bypass.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 16	5/21/99 6/17/99	Navani	B; BCR	2	1/2; r/q; 6 zones	Previous cardiac surgery.
DX 30	5/21/99 11/18/99	Wheeler	B; BCR	2	0/1; q/q; 4 zones	Healed anterior chest surgery for coronary artery bypass. Ill-defined small nodular infiltrate in both lungs mixed with calcified granulomata, probably mainly in periphery mid and upper lungs with some pleural involvement compatible with TB or histoplasmosis; suggest CT scan for precise localization of nodules since some could be pneumoconiosis. However, the pattern of silicosis and CWP should be symmetrical. Small nodules in central portion mid and upper lungs and on these views there is sparing of portion mid lungs near hila. A CT scan is best way to evaluate this case to confirm or exclude central nodules especially since these films are subpar quality and PA only.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 30	5/21/99 12/6/99	Kim	B; BCR	2	0/1; r/q; 4 zones	Peripheral nodules in the mid and upper lungs somewhat non-specific in distribution. Small granulomatous calcification seen in the right upper lung; Findings are compatible with granulomatous process with unknown activity; anterior chest wall surgery.
EX 2	5/21/99 11/18/99	Scott	B; BCR	3	1/1; r/q; 4 zones	Largely peripheral nodular infiltrates mid and upper lungs with some calcified granulomata on the right compatible with TB, unknown activity; anterior chest surgery.
DX 31	10/12/99 1/6/00	Wheeler	B; BCR	2	0/1; q/q; 3 zones	Healed anterior chest surgery for coronary artery bypass. Small ill-defined nodular infiltrates in lateral portion upper lobes and lower left apex compatible with TB unknown activity, probably healed. A few small nodules could be pneumoconiosis but pattern is asymmetrical and involves lower left apex making granulomatous disease more likely; muscular prominence or small benign asbestos related pleural plaques on lateral chest walls near lower scapulae.
DX 32	10/12/99 1/26/00	Kim	B; BCR	1	0/1; q/q; 4 zones	Nodular infiltrates in both upper lungs, probably granulomatous process, unknown activity; anterior chest surgery (probably CABG).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 29	10/27/99 11/18/99	Zaldivar	B; BCI; BCP	1	1/1; r/r; 6 zones	Previous coronary bypass surgery. Granulomas are also present in his lungs. The abnormal x-ray findings may be the result of recent pneumonias.
EX 2	10/27/99 12/29/99	Meyer	B; BCR	1	1/1; r/t; 4 zones	Prior coronary artery bypass surgery. Larger than typical CWP nodules– consider infectious granulomatous disease or metastases as well.
EX 12	1/14/00 1/14/00	Anton		not noted		Changes are suggestive of mild pulmonary edema and/or fluid overload superimposed over chronic interstitial disease. .
EX 12	1/16/00 1/16/00	McJunkin		not noted		Persistent vascular congestion with small bilateral pleural effusions.
EX 12	1/20/00 1/20/00	McJunkin		not noted		Improvement but persistent mild pulmonary vascular congestion and right pleural effusion.
EX 1	3/25/00 3/25/00	Dahhan	B, BCI, BCP	1	1/1; r/q; 6 zones	

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 3	3/25/00 5/1/00	Wiot	B; BCR	2	1/2; r/q; 6 zones	Pleural disease present on the right, with blunting of the costophrenic angle and pleural disease extending along the right lateral chest wall. Pleural disease is not a manifestation of coal dust exposure. It is probably related to the previous coronary by-pass surgery. Character of the nodules is somewhat different from those usually seen with coal workers' pneumoconiosis.
EX 4	3/25/00 5/5/00	Spitz	B; BCR	2	1/1; r/u; 6 zones	Findings consistent with pneumoconiosis but nodules appear somewhat different than the usual R and U nodules, bringing up the outside possibility that there may be some other etiology; pleural disease on the right could be related to previous chest surgery, but previous asbestos exposure cannot be excluded.
EX 8	3/25/00 5/20/00	Meyer	B; BCR	2	1/1; r/q; 6 zones	Prior coronary artery bypass surgery. Blunt right costophrenic angle. Several densely calcified nodules–consider infectious granulomatous disease like histoplasmosis versus simple CWP.

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; R- Radiologist; BCP-Board-Certified Pulmonologist; BCI- Board-Certified Internal Medicine; BCCC- Board-Certified Critical Care. Readers who are board- certified radiologists and/ or B-readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease

pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Decided under Part 727 of the Regulations).